

ARTICLE 16

SECTION 1

FRAUD PREVENTION AND REFERRAL

1. GENERAL

The purpose of this section is to provide instructions regarding fraud prevention and referral activities, and information on the role of the California Department of Health Services (CDHS) Investigations.

2. DEFINITION OF FRAUD

Fraud exists when a person, on behalf of him/herself or others, has:

- A. Knowingly and with intent to deceive or defraud made a false statement or representation to obtain benefits, obtain a continuance or increase of benefits, or avoid a reduction of benefits.
- B. Knowingly and with intent to defraud failed to disclose a fact which, if disclosed, could have resulted in a denial, reduction or discontinuance of benefits.
- C. Knowingly and with intent to deceive or defraud accept benefits to which he/she was not entitled, or accepted an amount of benefits knowing it is greater than the amount to which he/she is entitled.
- D. Made statements which he/she knew to be untrue for the purpose of: obtaining benefits, continuing to obtain benefits or avoiding a reduction or denial of benefits.

3. REFERRAL CRITERIA

Fraud investigations on Medi-Cal cases are conducted by the California Department of Health Services (CDHS) Investigators. If the Eligibility Technician (ET) has sufficient information to determine the amount of potential overpayment, the procedures outlined in Article 16, Section 2 are to be followed. If the ET does not have sufficient information and/or specific investigative techniques are required, the ET may refer the case to CDHS. Prior to making the referral, the ET must have taken all appropriate actions to obtain the information including contacting the client or key person, if appropriate.

Appendix A is a desk aid that provides criteria for use in evaluating whether a case should be referred to CDHS Investigations. In making the decision to refer, the ET must analyze the specific case situation in relation to all known facts about the client. When questions arise as to how a recipient is meeting the financial needs of the family, the ET must seek information from the client prior to making a referral. Automated Letters are available for the purpose of obtaining information when the recipient's expenses exceed his/her income. Unreported income is a possibility in such cases. A complete narrative of the steps taken by the ET to

explore the family circumstances is to be done and will help avoid information citations by Quality Control.

Reasonable grounds to suspect fraud may exist if the client provides unclear, conflicting or inconsistent information. Difficulty in obtaining verifications or non-cooperation by third-party contacts may signal a need for a referral. Documentation that appears to have been altered should be referred. If a questionable situation arises and the ET is unsure whether a referral is required, he/she should consult with his/her supervisor and/or the CDHS Investigator assigned to the district office before making the referral.

4. DISTRICT MANAGER RESPONSIBILITIES

A. Scheduling

The District Manager is responsible for ensuring that maximum time is given for an accurate evaluation of eligibility determinations. Although past practice may have been to use the full immediate need and expedited services time lines for scheduling, managers must apply necessary resources to ensure that immediate need and expedited services are scheduled for the same day as the request or no later than the next work day.

B. Automated Systems

The District Manager is responsible for ensuring that district staff is aware of and utilizes all automated information systems appropriate to the eligibility determination process.

5. ELIGIBILITY SUPERVISOR RESPONSIBILITIES

Eligibility Supervisors are responsible for reviewing the usage of the automated information systems (TUG, Chapter 1) with ETs to ensure they utilize the information available.

6. ET RESPONSIBILITIES

A. Fraud Prevention

To prevent fraud, the ET must make every effort to ensure that the applicant/recipient understands his/her responsibility for promptly reporting any factor which would affect the determination of eligibility or share-of-cost. In addition, the applicant/beneficiary must also understand the penalties for failing to report. These two responsibilities must be reviewed by the ET with the applicant/beneficiary at each application and renewal. Furthermore, the case record must be documented accordingly and must reflect whether or not the client demonstrated understanding of these explanations.

The ET is also responsible for taking prompt action on any information received or circumstances noted which could affect eligibility or require a change in the share-of-cost.

The ET is required to obtain all verifications mandated in program guide. It is the responsibility of the ET to review these verifications and to determine whether or not they are questionable or inconsistent. When verifications are conflicting, inconsistent, incomplete, or appear to have been altered, the ET should attempt to resolve these issues with the client to the fullest extent possible. If there still remains inconsistent or questionable information, the ET may initiate a referral to the California Department of Health Services Investigations.

B. Before the Referral

The following list includes examples of actions to be taken by the ET prior to a referral to the CDHS Investigator:

- 1) Ask the client how he/she has been supporting him/herself and any minor children prior to the application for aid.
- 2) Ask the client how financial needs are met if expenses exceed family income.
- 3) Review the verifications provided to determine if they are conflicting, inconsistent, incomplete or appear to have been altered.
- 4) Request employment verification from the last known employer. Client-signed release is required if the employer is contacted directly by DSS staff.
- 5) Determine if the spouse/absent parent is in the United States Military. If so, request the spouse/absent parent's Social Security number and request a signed release to obtain allotment verification. Then refer the case to the CDHS Investigator who will contact the military to obtain verification of any contributions to the client.
 - a) Be alert for applicants coming to San Diego from areas which have military bases.
 - b) Be alert for any cases where the client claims to be residing with friends or relatives who live in naval housing.
- 6) Question the client as to the reasons for obtaining a Delayed Birth Certificate, obtained within the last year. Request the client to provide the back-up (second party) information which was used to obtain the delayed birth certificate.
- 7) Ask the following questions when residence outside of the United States (U.S.) is suspected.
 - a) Ask the client if he/she has other children for whom he/she is not applying, and if so, where are they residing.
 - b) Ask if the spouse/absent parent is outside of the U.S. and attempt to obtain his/her address and current place of employment.

- c) Ask the client about any property they own or control, not only in the United States but also outside of the United States.
 - d) Ask each parent's full name and address, and the period of time the client resided with his/her parents, if the applicant states he/she was living with his/her parents outside of the U.S.
 - e) Question the client when he/she states the spouse/absent parents' whereabouts are unknown but believed to be outside of the U.S. Question cases where the client has stated the spouse/absent parent is currently outside of the U.S., but it is determined that the client and absent parent resided together at some point in time in the United States and the absent parent has had prior employment in this country.
- 8) Photocopy both sides of all I.D. cards presented. The photocopies should accompany the investigation referral.
 - 9) Obtain the license plate number of all vehicles when ownership is questionable. These numbers should be referred to a CDHS Investigator for verification.
 - 10) Ask for a receipt and a rental agreement and/or a receipt from San Diego Gas and Electric Company indicating that the utilities have been turned on at the indicated address if residence is in doubt.
 - 11) Check Assessor Screen to verify ownership of property and/or existence of given address.

7. EARLY FRAUD DETECTION PROGRAM - INTAKE

Because fraud prevention is one of the most cost effective and expedient ways to identify fraudulent cases, Medi-Cal intake cases will be given the highest priority by CDHS Investigations. Intake workers will promptly make referrals to the CDHS Investigators assigned to their district upon discovery that a referral is appropriate.

CDHS Investigators recognize the urgency of Medi-Cal fraud referrals, and will attempt to respond to the intake worker within ten (10) calendar days. It is understood that certain Medi-Cal applications have a shorter turnaround requirement. To the extent possible, the CDHS Investigator will attempt to give those cases priority. In the event that CDHS Investigations does not have enough staff to cover every office, referrals may be prioritized by CDHS. The earlier in the process a referral is made, the better the chance that the ET will have the results of the investigation before granting the case.

In some instances, it may be necessary to grant aid prior to the completion of the investigation in order to meet immediate need or promptness requirements. Under these circumstances, the granting may not be delayed pending the completion of an investigation so long as all inconsistent and conflicting/questionable information has been resolved. Refer to 16-1-9.B for action required prior to taking action to grant the case.

8. FULL FIELD INVESTIGATION - GRANTED CASES

If a case has been granted for more than 90 days, a referral can be sent to the CDHS Fraud Prevention Investigator for preliminary investigation. The CDHS Fraud Prevention Investigator assigned to the HHSA district office will follow-up on the referral to determine if there is fraud that may affect current eligibility. In some instances, cases that are granted more than 90 days will require full field investigations. These cases may require more time and, accordingly, another Investigator may conduct the full field investigation.

9. CDHS REFERRAL

A. Referral Process

Referrals will be made on the 14-58 HHSA form (Appendix B), indicating in the upper right box that the referral is to Medi-Cal. The ET will clearly indicate the basis for the referral on the 14-58 HHSA, and note if this is a Minor Consent or mail-in application. Inconsistent or conflicting information, or the specific information the ET needs from the CDHS Investigator will be noted by the ET on the referral. The ET will:

- 1) Include a copy of the following with the referral, as appropriate:
 - a) Current LMO
 - b) Screening sheet (16-2A DSS)
 - c) MC 210 (portions related to the referral)
 - d) Identification documents, rental receipts, passports, and INS documents including border crossing cards that the client may have voluntarily provided
 - e) Documents that are of questionable authenticity
 - f) Sworn statements or declarations by providers of housing
 - g) Prior investigation reports
- 2) Place the top three copies of the 14-58 HHSA referral in the district designated CDHS Investigation basket/area.
- 3) Retain the goldenrod copy for the case file.

When the Investigator has completed the investigation, he/she will complete section 2 of the 14-58 HHSA with as much detail as possible and attach any documents or affidavits obtained. The Investigator will return the white and yellow copies to the ET and retain the pink copy for the CDHS file.

The ET will note action taken as a result of the Investigator's response on the HHSA, retain the white copy for the case file, and return the yellow copy to the CDHS Investigator. A response to the CDHS Investigator is not required when fraud is not found.

If the client presents additional information and/or verifications to rebut the Investigator's findings, the information/verifications must be reviewed for inconsistency. The ET is to inform the CDHS Investigator of the additional information/verification received.

B. Referral Pending

When the referral is made at intake level, the decision to grant may not be delayed pending the Investigator's response if all eligibility requirements are met and the verifications are not questionable. If additional verifications are required prior to granting, the ET will inform the applicant of what is required and provide assistance in obtaining the verification if necessary. In general, the ET must continue the eligibility determination process while the fraud prevention investigation is being conducted.

When the ET is ready to grant the application and a fraud prevention referral was made at least one week prior, the Eligibility Supervisor will contact the appropriate Supervising Investigator to determine the status of the investigation. The ET must take the appropriate case action if the Eligibility Supervisor has not received a response from the Supervising Investigator within one day.

10. SOLICITATION REFERRALS

A. General

Welfare & Institutions Code (W&IC), Section 14014, states that "Any person receiving health care for which he was not eligible on the basis of false declaration as to his eligibility, **or any person making false declarations as to eligibility in behalf of any other person receiving health care for which such other person was not eligible** shall be liable for repayment and shall be guilty of a misdemeanor or felony depending on the amount paid in his behalf for which he was not eligible."

Senate Bill (SB) 1131, which became law on January 1, 1994, states that "every person who, with the intent that the crime be committed, solicits another to commit an offense specified in W&IC 14014 shall be punished by imprisonment. **Counties that suspect or have evidence that an authorized representative, family member, provider or other persons have intentionally solicited an applicant/beneficiary to falsify information in order to obtain Medi-Cal must refer this information to their respective Department of Health Services Investigations office.**"

SB 1131 amended California Penal Code Section 653f to impose penalties ranging from misdemeanor to felony convictions on persons who intentionally solicit another to make false declarations for the purpose of obtaining Medi-Cal benefits.

B. Definition of Solicitation

Soliciting, as related to fraud, is the act of tempting or enticing someone to do wrong. This includes advising Medi-Cal applicants how to answer questions, conceal information, or provide false or fraudulent information to:

- 1) Establish eligibility to Medi-Cal program benefits, or
- 2) Obtain a greater Medi-Cal program benefit than would otherwise be available, or

- 3) Prepare for investigation of their circumstances by Medi-Cal representatives, including California Department of Health Services Investigators.

C. ET Responsibilities

ETs are required to take prompt action on any information received or circumstances noted which raise suspicion that solicitation is involved.

Required Actions

- 1) Complete Sections A and B on the Solicitation Referral Form 14-56 DSS.
- 2) Include a copy of the following with the referral, as appropriate.
 - a) SAWS1, MC210, MC219, CMS 216, CMS 217
 - b) Any available documentation supporting the solicitation allegation.
- 3) Place the top two copies in the district designated California Department of Health Services (CDHS) Investigation basket/area. HOS staff will continue to send or fax the referral to CDHS Investigations.
- 4) Send the pink copy to the District Manager.
- 5) Retain the goldenrod copy for the case record.
- 6) Tic the case for 45 days. If no response has been received, contact the CDHS Investigator to obtain an investigation status update.
- 7) Complete a narrative entry explaining the circumstances which prompted initiating a referral.

REMINDER: Staff are not to discuss any investigation with the client.

D. CDHS Responsibilities

CDHS views solicitation referrals as high priority. They are considered full field referrals.

CDHS will:

- 1) Enter the date the referral was received by CDHS.
- 2) Provide the ET with status update every 45 days.
- 3) Provide final findings by completing section C of the Solicitation Form and returning it to the District Manager.

E. Follow-up Procedures

Within five (5) working days from receipt of a written response from CDHS, the district manager will forward the response to the ET for case action. The results of the investigation may or may not affect the case.

District managers will monitor solicitation referrals to ensure appropriate follow-up procedures are completed, and to determine CDHS investigation findings. Managers will keep their Assistant Deputy Director informed of the results of CDHS investigations of solicitation referrals.

11. ET DISAGREES WITH FINDINGS

CDHS Investigations staff make recommendations to the ET on the suggested disposition of the referral. If the ET disagrees with the recommendation of the CDHS Investigator, the ET will discuss the difference of opinion with his/her Eligibility Supervisor and the CDHS Investigator. If agreement is not reached, the case will be referred to the District Manager who will resolve the difference of opinion through discussion with the appropriate CDHS Supervising Investigator. It is understood by CDHS Investigations that the ultimate eligibility determination is the responsibility of the DSS eligibility staff and managers.

12. CLOSED CASES

Complaints or information received indicating possible fraud on closed cases which are in Records Library, are to be referred to the fraud hotline. Refer to 16-1-14. below.

13. INVESTIGATIONS INFORMATION

When a questionable situation arises and the ET is unsure whether a fraud referral is warranted, the ET may contact CDHS Investigations at (619) 645-2826.

14. FRAUD HOTLINE

The Fraud Hotline is answered during normal working hours. The California Department of Health Services (CDHS) operates a toll-free hotline for Medi-Cal fraud complaints. The hotline telephone number is:

CDHS Southern Region Investigations
1-800-822-6222

15. COMMUNITY COMPLAINTS - DISTRICT RESPONSIBILITY

When a community complaint is received directly into the district, the ET is to obtain the complainant's name and address (if he/she is willing to provide this information), the nature of the complaint, and case identifying information. Community complaints of fraud will be investigated to the extent possible for resolution by the ET of record. Unresolved fraud

complaints will be referred to CDHS on an MC 609, Medi-Cal Complaint form (See Article 16, Section 2, Appendix A), as appropriate, unless the information is already in the case record.

Community complaints regarding behavior which does not conform to community standards are not appropriate fraud referrals; however, an evaluation of service needs should be made. For example, an indication that children's care or supervision is inadequate may require a Child Protective Services (CPS) referral.

16. NON-ELIGIBILITY RELATED FRAUD

Non-eligibility related fraud in the Medi-Cal program falls into two categories: provider fraud and misuse of Medi-Cal. Staff may be contacted by persons with information regarding non-eligibility related fraud. Staff should refer such contacts to the toll-free CDHS complaint number: 1-800-822-6223.

17. SYSTEMS AVAILABLE TO ASSIST IN FRAUD PREVENTION

A. Income and Eligibility Verification System (IEVS)

IEVS provides both Intake and Granted ETs with information from data matches with other agencies including Social Security Administration, State Employment Development Department and Franchise Tax Board, using a client's social security number. ETs must make use of the information available through IEVS, especially in cases where there is conflicting information which may be resolved through this data match process.

For detailed information on IEVS, refer to Terminal User's Guide (TUG), Chapter 1, Appendix G; and IM-EDP Manual, Chapter 12.

IEVS can help reduce the need to refer applicants to the Employment Development Department (EDD) to verify the receipt or nonreceipt of benefits. It helps to identify missing or erroneous applicant information. It reduces future workload by reducing or preventing an overstated/understated SOC. IEVS provides a computerized match of applicant/recipient name, date of birth in some cases and Social Security Number (SSN) with the following information sources:

- 1) MEDS/CDB Eligibility History file.
- 2) EDD wage, employment and disability files (UIB and DIB).
- 3) Franchise Tax Board (FTB) interest and dividend information.
- 4) Retirement, Survivors, and Disability Insurance (RSDI) benefit information from Social Security Administration (SSA) files.
- 5) SSA/IRS wage and self-employment income information from the Benefit Earnings and Exchange Record (BEER) files.

B. IEVS Systems

IEVS is divided into two systems, the applicant system and the recipient system.

1) Applicant System

The applicant system provides information on applicants during the intake process on a computer printout entitled "IEVS Summary Abstract." This abstract report matches with the files listed above except for the BEER file.

When all matches have been made, the abstract is printed and distributed to the district ET of record.

2) Recipient System

The recipient system consists of several subsystems: the Payment Verification System (PVS), Earnings Clearance, which is also known as Integrated Fraud Detection (IFD), Asset Match, and BEER.

a) PVS

The Payment Verification System (PVS) is a monthly match that provides information on RSDI benefits, UIB, and DIB. The PVS information is received as a computer printout which is distributed around the 5th or 6th of each month to the district ET of record. The district ET has responsibility for clarifying discrepancies with the applicant/recipient. PVS reports RSDI information on an exception basis so ETs will get RSDI reports only when there is a change.

b) NHR Data Match

The New Hire Registry (NHR) data match is a monthly match that provides information on new or reinstated employment of Medi-Cal beneficiaries. Mandated employers must report to the NHR system when an employee is newly hired or rehired within the last 20 days. Matches are completed based on the Social Security number for the month of reported employment. Three reports are produced.

- The NHR 420 Roster provides a summary list, by county, of all cases identified during the match process. (Appendix D1)
- The NHR 415 Roster provides a summary list, by worker, of all cases identified during the match process and the total of cases per worker. (Appendix D2)
- The NHR 410 Roster provides an alert with detailed data match information for the identified case/beneficiary. (Appendix D3)

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The Overpayment Specialist Unit (OSU) has the responsibility for reviewing the NHR matches to determine if the match is valid for all matches other than Aid Code 38/39 or closed cases tracked to Record Room. OSU will notify the worker via the NHR Alert form if the employment was unreported or was reported and not acted upon. OSU will compute the potential overpayment and make the referral to CDHS if the case is referred for an overpayment review.

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The FRC Corrective Action Supervisor (CAS) will receive the NHR 415 Rosters from OSU with instructions. The CAS will instruct workers to pull cases by the review date and place them in the OSU workstation. If a case is returned with a NHR Alert, the worker, within 10 days of receipt of the NHR Alert form, will request verifications from the beneficiary and take appropriate case action. The CAS will receive the original alerts and monitor that appropriate action is taken. The worker will determine if a potential overpayment exists and generate an OSU Referral form 07-126A via the AES0 system. Form 07-126A will be attached to the front of the case and placed in the OSU workstation for review.

Note: NHR matches identifying employment information, which will not affect eligibility or benefit level, are to be filed in the case for review at a later date. (See MPG Article 16, Section 1, Item 17-E-2.)

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c) ECS/IFD

The Earnings Clearance System (ECS) match is a quarterly report of wage data from EDD compared to wages reported to the counties by recipient. ECS matches are processed by OSU staff.

d) Asset Match

The Asset Match is run yearly and matches against the State Franchise Tax Board's (FTB) annual interest and dividend file in order to identify recipients who received interest or dividend income in the previous year. Asset matches are processed by OSU staff.

e) Benefits Earnings and Exchange Record (BEER)

BEER reports are received annually on all recipients and monthly for newly eligible recipients. They contain data from the previous tax year including: self-employment income, out-of-state wages, military wages, federal wages and California wages not reported to EDD. BEER reports contain information from Internal Revenue Service (IRS) records. The IRS Code stipulates certain safeguard conditions, which must exist in order to meet minimum protection standards. Because of these restrictions, workers will NOT have access to BEER reports. Information has been verified in accordance.

OSU will have responsibility for BEER reports. BEER data will be kept in either a locked room or file when not in use, after normal working hours, weekends and holidays. BEER reports are confidential destruct materials and will be maintained in a locked container until destroyed.

C. IEVS Data Collection

Regulations require that data must be collected and submitted for all persons applying for federally funded AFDC, MCO, FS, RCA, and RDP. At pre-application it is generally not possible to determine federal/non-federal participation. Therefore, when a case is opened to CDS, IEVS data will be collected on all applicants for the above programs, provided there is valid "H" and "J" line data sent to CDS.

Other persons whose data should be collected and submitted to IEVS are those individuals whose income and resources are considered in the eligibility determination. However, if a SSN is not available for anyone who is not an applicant or recipient, the household unit's eligibility shall not be affected.

1) Applicant Data Submission

The County must input applicant data into IEVS at the first available opportunity following the receipt of the necessary information from the applicant, but no later than five working days after the signed Statement of Facts is completed. Entries submitted at the pre-application interview will meet this State requirement. Workers who process applications that do not go through AIS pre-application should be aware of the five working days requirement for submission of IEVS data.

When a SSN is not available at application, information on the individual must be submitted to the Applicant System as soon as a SSN is available, even if the application has already been granted. An individual's information is usually submitted to IEVS via CDS entries (see the CDS code and Message Handbook, Generic Section for MCG codes which trigger an IEVS transaction).

2) Recipient Data Submission

Data is submitted automatically for the Recipient System. Recipient System reports will be produced for all individuals when a match is found.

D. IEVS Inquiry

Workers may access or query the IEVS data base for an individual or entire case. The inquiry will display all matches that have been made as of the date the inquiry. Approximately 60 days after a response has been received from each of the match agencies and the applicant records will be purged. IEVS screens and router instructions are in IM-EDP Manual.

IEVS inquiry may be used to check for matches made prior to receipt of an abstract, and to verify that data has or has not been submitted to the IEVS database.

After all matches with MEDS/CDB, EDD and FTB files have been made an applicant abstract will be printed in district. This usually takes four to five days after submission of the information to the IEVS database.

E. Processing IEVS Reports

1) Review Report Summary

Upon receipt of an IEVS report, the worker must review the information in the report to ensure that correct case data was submitted to IEVS. If the applicant/receipt information is correct, review the match results columns to see which, if any, inquiries resulted in a match. If name, SSN, DOB, or sex are incorrect for any applicant/recipient, resubmit to IEVS for that person by entering the appropriate MCG code and any corrected/changed person information. (See IM-EDP, Code Book for MCG codes.)

2) Review Match Information

Review and compare the IEVS information against information contained in the case record to determine whether it applies to the application/recipient or whether the information has an affect on eligibility or benefit level. Factors to be considered in this determination include:

- Complete and positive match between the IEVS match and identifying case information;
- Agreement with other information contained in the case record or otherwise available to the county;
- Appropriateness of the information in relation to the known circumstances of the applicant; and
- Information, which will not affect eligibility or level of benefits (e.g., new employment information for a child protected by Continuous Eligibility for Children or a child with full time student status).

If not the same person, resolve the discrepancy and resubmit to IEVS if necessary. For example, confirm that an adult family member has not been using a child's SSN when the IEVS abstract shows UI benefits for a young child. If information will not affect eligibility or level of benefits, narrate receipt of the IEVS and file for review at the first occurrence of the annual redetermination or when exemption status ends.

3) FEIN and SEIN Numbers

Federal Employer Identification Numbers (FEIN) and/or State Employer Identification Numbers (SEIN) are shown on IEVS documents along with the name and address of the employer or financial institution. In some instances, only the FEIN or SEIN number is shown without the name and address of the employer or financial institution.

A microfiche listing of FEIN and SEIN numbers and the corresponding employers is maintained in the clerical section of OSU. District workers may access this list by

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sending a gram with the FEIN or SEIN number, the worker Name, number and Mail Stop to the Asset Match Specialist at W416. If the information is needed immediately, the worker may call the Asset Match Specialist in OSU.

4) Invalid Reports

If information on a report does not apply to any case member, then the report is invalid. If part of the information on an abstract is erroneous while other information is correct, the erroneous information must be blacked out. IEVS information shall be used only to determine eligibility. Care must be taken to protect the information from unauthorized use.

Abstracts from all matches which are completely invalid or otherwise inapplicable to the case must be destroyed through confidential destruction methods. These abstracts **MUST NOT BE PUT IN WITH REGULAR WASTEPAPER/TRASH** that is not disposed of as confidential. Dispose of invalid abstracts in the DISTRICT CONFIDENTIAL RECYCLE BINS.

F. Report Information

1) IEVS as Verification

IEVS UI/DI and RSDI match results which confirm information the applicant/recipient supplied on the Statement of Facts are from a primary source and may be used as verification as indicated in Article 4, Section 6.

Information from a secondary source, such as EDD wage or FTB resource information cannot be used as verification.

2) Resolution of Discrepancies

Any information that is "significantly different" from applicant supplied information must be clarified. Significantly different means that the difference between the applicant supplied information and IEVS match results could impact current or prior eligibility, or share of cost.

If possible, such discrepancies should be discussed at the application interview and resolved before granting. When information is received after the application interview, the worker must contact the applicant immediately, inform him/her of the IEVS information which is significantly different from current or prior applicant information and request clarification. Article 4, Sections 6 and 8 provide instructions for clarifying discrepant information.

3) Asset Match

If an IEVS abstract is received before a case is granted and it shows an undisclosed asset, the worker should follow standard program procedures for resolving the discrepancy. If the information is received after a case is granted and there is an

Asset Match discrepancy, the discrepancy must be resolved by using the IEVS Contact Letter, form number 16-18 and the IEVS Resource Questionnaire, form number 16-19. The resource questionnaire will be used as case documentation of the resource and must be completed by the applicant or the ET. Use Article 4, Section 8 for Asset Match discrepancy procedures.

G. Case Activities

1) Processing Standards

a) Time Frames

The Applicant Abstract, PVS, NHR match and ECS information must be reviewed and acted upon for active cases within 45 days of the "match date" or "run date" on the report for all aid types on 80 percent of the cases with matches. Reviewed and acted upon means that the data match must be reviewed to determine if the individual identified is the Medi-Cal beneficiary and acted upon by requesting verifications if the information is new or previously unverified. The 45-day time frame does not include the additional time required for the Medi-Cal beneficiary to return the income/employment verifications. Action taken on potential overpayment reporting or completion of the County response does not fall within the 45-day time frame.

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b) Granting Actions

Receipt of the applicant abstract is not required before granting. However, with the CPU link, on-line inquiry to IEVS will be required as stated below. IEVS does not supersede standard program rules on determining and granting eligibility. IEVS information is to be used as an additional information and/or verification source, if available, prior to granting eligibility.

Mandated IEVS on-line inquiry will be implemented on an incremental basis for cases in which an IEVS abstract has not been received prior to granting or being sent to Granted. The mandated implementation will be in two stages - Immediate and Ongoing.

(1) Immediate

Effective with the receipt of this letter on-line inquiry will be completed at the intake whenever it is known or suggested that there was an application within two months prior to the intake for any member of the household for whom IEVS is a required referral.

(2) Ongoing (Effective 12-1-89)

On-line inquiry will be completed when the intake is at least three work days from the application date when:

(a) UIB/DIB information is suspect and/or there has been previous failure to report UIB or DIB; or

(b) Verification of UIB or DIB application is pending.

On-line inquiry will be completed when the intake is at least five work days from the application date in all other situations.

c) Closed Cases

(1) Applicant Abstracts

If a case is denied before receipt of an IEVS Applicant Abstract or denied for reasons unrelated to IEVS the abstract does not have to be processed. The abstract must be filed in the case file or forwarded to the Records Library.

(2) Recipient Reports

(a) Medi-Cal regulations do not require follow through on closed cases. PVS reports on deceased persons should be destroyed.

OSU will process PVS reports that have a run date 30 days after the negative action date on a closed case. If the case has been closed for less than 30 days or if a case reopens in the month following discontinuance, the ET of record is responsible for processing the report. To refer a PVS to OSU, place the PVS report and case, if available, in the district area designated for OSU reviews.

(b) ECS, BEER, and Asset Match

OSU will process the ECS, BEER and Asset Match on closed cases according to program specific criteria.

2) Case File

a) Applicant Abstract

All cases leaving intake must contain a returned abstract for each person receiving assistance.

OR

The case must be flagged by the intake ET for the granted ET to check for return of any missing abstract. Districts may use their own flagging system to denote missing abstracts.

If an abstract is not received within thirty days, the ET of record must follow-up. The follow-up can include:

- (1) Checking with previous intake or preapp staff for receipt of the abstract.
- (2) Doing an on-line inquiry to determine if all matches have been made.
 - (a) If all matches have been made, request an IEVS screen print via the 14-28.
 - (b) If a match is still pending, check existing matches against the case information for possible discrepancies. If there are no discrepancies note this in the file and set a new flag for ten days. If the inquiry information indicates a discrepancy, request an IEVS screen print via the 14-28 and resolve the discrepancy.
- (3) Initiating a CDS transaction to IEVS by use of a "V" in the MCG box, if an inquiry shows that an individual's information has not been received by IEVS and set a new flag for 20 days.

b) Where to file

The abstract(s) once processed, should be filed under the "other verification" tab. The PVS once processed, should be filed under the "Income Report" tab. The IFD/ECS is filed under the "Overpayment" tab and Asset Match reports should be filed under the "Property" tab.

3) Case Documentation

The outcome of all IEVS matches must be noted in the case file. Notation must be made on the report. The notation must include the date of final processing, the ET's name and ET number.

4) ET Communication

If a recipient is receiving other aids, assigned to more than one ET, and an IEVS discrepancy is discovered, the ET identifying the discrepancy must contact any other ETs to note case actions being taken.

5) Negative Actions

When a denial, discontinuance or benefit reduction is done due to IEVS information, a "V" must be entered on CDS, line "L," Special Characteristics Box "D." This entry will allow for tracking of IEVS related negative actions.

H. Systematic Alien Verification for Entitlement (SAVE)

The SAVE system allows the Immigration and Naturalization Service (INS) to share information through an automated (also called primary system, by entering the alien number in the RR/HIC/DA NBR field on J line of the Person screen) and manual (secondary) systems.

CDS automatically sends the client's alien number to INS. The information that is returned from INS to the ET from the primary SAVE system will indicate if the client has legal immigration status. If the primary system indicates there is a problem with the client's documentation, the ET then must send a manual request (G-845) to INS, along with the documentation provided by the client, to verify if the client possesses legal immigration status.

I. Medi-Cal Eligibility Determination System (MEDS)

Another tool that ETs may use to prevent fraud is MEDS, which identifies all recipients who receive Medi-Cal in California. MEDS may be helpful in preventing/identifying duplicate aid cases.

The "Known To Welfare" screen on the MEDS Network, under the "Income and Eligibility Verification System" main menu, can be used to identify whether a client has received AFDC, Food Stamps, Medi-Cal and/or Homeless Assistance within California.

J. Central Data Base (CDB)

CDB is a state-wide data base which is available to verify current and historical receipt of Food Stamp benefits anywhere in California.

K. Social Services System Index (SS)

The system allows ETs to review previous and current case records and activities in San Diego County for all aids.

L. Assessor/Secured Property Inquiry

This system allows ETs to determine the owner of a property parcel, the assessed value of the property or if a property actually exists. This helps the ET determine if the client is giving conflicting information regarding his/her address or resources.

M. Jail Clearance

Allows the ET to verify if a client, such as an absent parent is in or out of jail.

N. Recorder's Marriage and Death Index Files

Allows the ET to verify a client's marriage and/or death records filed with the County Recorder's Office (Refer to Terminal User Guide Special Notice No. 95-2).

For detailed information and procedures to access systems listed on items C. through G., refer to TUG Chapter 1.

APPENDIX 16-1-A
POTENTIAL MEDI-CAL FRAUD INDICATORS
*Mandatory Fraud Referral

Is case documentation valid?

- Ask if they have identification (ref: MPG 4-7A)
- * · SS card appears fraudulent. (No raised print or watermarks/diff. ink)
- * · Required verifications appear altered, questionable or inconsistent
- I.D. is generic (check cashing card), not issued by a government agency

Are there any discrepancies or inconsistencies in the information provided by the client?

- Information on hospital records is different than the case information
- * · Does not know address or names of persons in the home
- I.D. was recently obtained but claims to have lived here longer
- Client claims to be undocumented but has a pay stub with SSN
- Using child's Social Security Number
- * · Client has a round trip ticket from country or state of origin
- * · Continues to have children by the same absent father
- Household composition appears questionable
- * · Client drives a car with license plates from another country
- * · Client presents a Border Crossing card or Non-resident Visa as I.D.
- * · Postmark on envelope of mail received from client indicates out-of-state origin.

Was aid recently denied or discontinued, and if so does the reason still exist?

- * · Applicant reapplies with a new address - Previously denied based on residence
- * · Transfers (LTC applicant/recipient) or sells property but has no proof/verification
- * · Change in applicant's financial situation or employment
- Change in linkage
- * · Prior application denied by HOS and client now applying in a district office.

How were the client's medical and financial needs met prior to the application?

- * · Applicant was receiving medical treatment outside the U.S. and now requests treatment here.
- Received free in-kind support
- Monthly expenses exceed income
- No income, assets or ability to work
- * · Employer refuses to complete income verification
- Client claims to work out of country
- Client claims to be paid in cash
- Self-employment applicant declares little profit or net loss
- Purchased or financed a car, boat or recreational vehicle
- * · Client is currently hospitalized and the key person has chosen to apply in the district office instead of applying through HOS staff.

Are there any previous fraud referrals? If so,

- Has the issue been completely resolved by CDHS Investigators?
- * · Are there any current issues relating to a previous referral?

Is the client requesting restricted Medi-Cal benefits and has conflicting/questionable documentation?

- * · An out of country/state voter registration
- * · ID from a grocery store
- * · A current/expired drivers license or California ID

APPENDIX 16-1-B

County of San Diego
Health and Human Services Agency

Date of Application _____
Date of Granting _____

Case Status: Pending Active

MEDI-CAL FRAUD PREVENTION REFERRAL

SECTION 1 (To be completed by ET. See back for required attachments):

FROM:	ET #:	PHONE:	DATE:
CASE NAME:	CASE #:	PRIM. LANG:	
ADDRESS:	PHONE:		
PROBLEM/COMPLAINT:			

SECTION 2 (To be completed by Investigator):

FROM:	PHONE:	DATE:
INVESTIGATION RESULTS:		

See page two for further explanation.

SECTION 3 DISPOSITION (To be completed by ET):

FROM:	ET #:	PHONE:
Denied _____ Date	Discontinued _____ Effective Date	No Action Change in SOC

See attached for further explanation.

If the ET disagrees with the recommendation of the CDHS Investigator, refer to MPG Article 19, Section 1, Item 9.

14-58 HHSA (5/98)	(File: Overpayment tab)	(05-00)
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APPENDIX 16-2-B

14-58 HHSA INSTRUCTIONS

ET INSTRUCTIONS:
<p>To request a fraud prevention investigation, complete <u>all</u> parts of Section 1, including as much detail as possible in the PROBLEM/COMPLAINT area. Attach copies of the following documents as appropriate (NOTE: referrals submitted without appropriate attachments will be rejected by the Investigator):</p> <ul style="list-style-type: none">• Most current Case Documentation Report, Budget Input Report, LMO, 278F, 16-2A, MC210, as needed. Provide the Investigator with the applicant's most current identification and as much information as possible on declared household/family member composition, income, resources, employment, reason for previous closing, immediate need request/reason, etc.• Current CA2.1, if complaint involves absent parent issues.• Copy of any documents of questionable authenticity or as pertinent to the problem/complaint (sworn statements, pay stubs, birth certificates, etc.) <p>Submit top 3 copies of 14-58 HHSA and attachments to Investigator. File goldenrod copy in case.</p>
INVESTIGATOR INSTRUCTIONS:
<p>Complete Section 2 with as much detail as possible, including recommendations to the ET on the suggested disposition of the referral in the INVESTIGATION RESULTS area when applicable. Attach page two if additional space is needed. Attach copy of any documents obtained in course of Investigation. Return white and yellow copies to ET. Retain pink copy.</p>
ET DISPOSITION INSTRUCTIONS:
<p>Refer to MPG Article 19, Section 1, Item 9, if ET disagrees with the recommendation to the CDHS Investigator.</p> <p>After investigation results are evaluated and appropriate action taken, complete the appropriate areas in Section 3. Return yellow copy of 14-58 HHSA to Investigator. Retain white copy in case file under overpayment tab. Goldenrod copy is to be destroyed in a confidential manner.</p>

APPENDIX 16-1-C

MEDI-CAL COMPLAINT REPORT — SOLICITATION REFERRAL

Section A

Case Name: _____ Date: _____

Case No.: _____ ET Name: _____

Date of Application: _____ ET No.: _____

Status of Case: _____ District No.: _____

Person Reporting Complaint (if other than ET):

Name: _____

Address: _____

Phone No.: _____

Section B

DETAILS OF COMPLAINT: (If additional space required, continue on an attached sheet of paper)

Name of person/provider soliciting — if known: _____

Synopsis: (State facts of the situation)

Specific Concerns: (State exactly what the concern is, e.g., client not here to sign authorized rep form, appears AR signed client's name; client told by person not to report residence out of California, etc.)

Attachments: (List all attachments provided and include any additional documentation pertinent to the situation and concern described above.)

Section C

COMPLETED BY CDHS INVESTIGATIONS

Complaint Received: _____

Date

Investigation Results:

Date Report Completed: _____ By: _____

(Investigator Name)

Distribution:

White & Yellow — CDHS

Pink — DM

Goldenrod — Case file

14-56

DSS

NEW HIRE REGISTRY COUNTY SUMMARY LIST

NHR420 ROSTER

DEPARTMENT OF SOCIAL SERVICES

*

IEVS/NEW HIRE REGISTRY

CONFIDENTIAL INFORMATION

RUN DATE 01/30/2001

PAGE 257

*

CASE IDENTIFICATION				COUNTY OF		PERSON			
AID	CASE	NBR	FBU	NBR	CASE NAME	DIST	EW		
		0	12		, BERN				
		2	12		, KERR				
		0	14		, PAME				
		2	14		, HILD				
		0	12		, DEBR				
		0	11		, MARL				
		2	12		, CAND				
		B	02		, LYND				
		0	12		, CARO				
		2	12		, THER				
		A	13		, GEOR				
		2	12		, DORI				
		0	01		, KELL				
		0	01		, ANGE				
		3	13		, ALMA				
		0	01		, JOAN				
		2	12		, CASS				
		2	12		, KAMM				
		5	15		, ALIC				
		1	13		, EVA				
		2	14		, EVA				
		A	11		, CATH				
		0	01		, MARY				
		3	01		, ABRA				
		0	13		, TANY				
		0	01		, TANY				
		3	12		, ELIS				
		B	13		, CYNT				
		A	12		, LETI				
		3	01		, MARI				
		0	01		, THEC				
		2	12		, CHAR				
		0	01		, ROSA				
		2	12		, JANE				
		3	13		, DEBR				
		0	02		, MARI				
		0	01		, MARI				
		0	12		, KELL				
		2	12		, KATH				
		0	03		, RACH				

NEW HIRE REGISTRY WORKER SUMMARY LIST

NHR415 ROSTER DEPARTMENT OF SOCIAL SERVICES

***** IEVS/NEW HIRE REGISTRY

CONFIDENTIAL INFORMATION RUN DATE 01/30/2001

PAGE 1

COUNTY OF

DISTRICT:

CASE IDENTIFICATION

AID	CASE	NBR	FBU	PERSON NBR	CASE NAME	EW
		2	14		, EVA	
		0	01		, SUSA	
		0	01		, JENN	
		0	01		, KAND	
		0	01		, TERE	
		0	01		, ANGE	

TOTAL WORKER CASES: 6

NEW HIRE REGISTRY WORKER INDIVIDUAL ALERT

STATE OF CALIFORNIA
NHR410
RUN DATE: 01/30/2001

DEPARTMENT OF SOCIAL SERVICES
IEVS/NEW HIRE REGISTRY
COUNTY OF

ROUTE: - -
CO DS EW
PAGE 1

CASE INFORMATION
CO CASE NO. FBU
0

CASE NAME

, ROCI

-----NEW HIRE REPORTED BY EDD-----

INFORMATION SENT TO EDD

-----NAME-----				SEX	DATE OF	SSN	
LAST	FIRST	M	V	PER	C	CODE	NO
	ROCIO		F	/ /	- -	J	01

INFORMATION RETURNED BY EDD

EMPLOYEE LAST NAME-----	FIRST-----	MI
HIRE DATE	CAPTURE DATE	
JANETTER	01/04/2001	01/25/2001

--- EMPLOYEE ADDRESS-----
INFORMATION

ACCOUNT NO. FEIN

-

-

--- EMPLOYER NAME AND ADDRESS-----

EMPLR CO

SIC/NAICS

-

WORKER NAME/:-----
REVIEW:-----

DATE OF

IF NO DISCREPANCIES, CHECK THIS BOX _____

FILE IN CASE

***** END OF CASE *****

**** CONFIDENTIAL INFORMATION *****
CONFIDENTIAL INFORMATION ***

